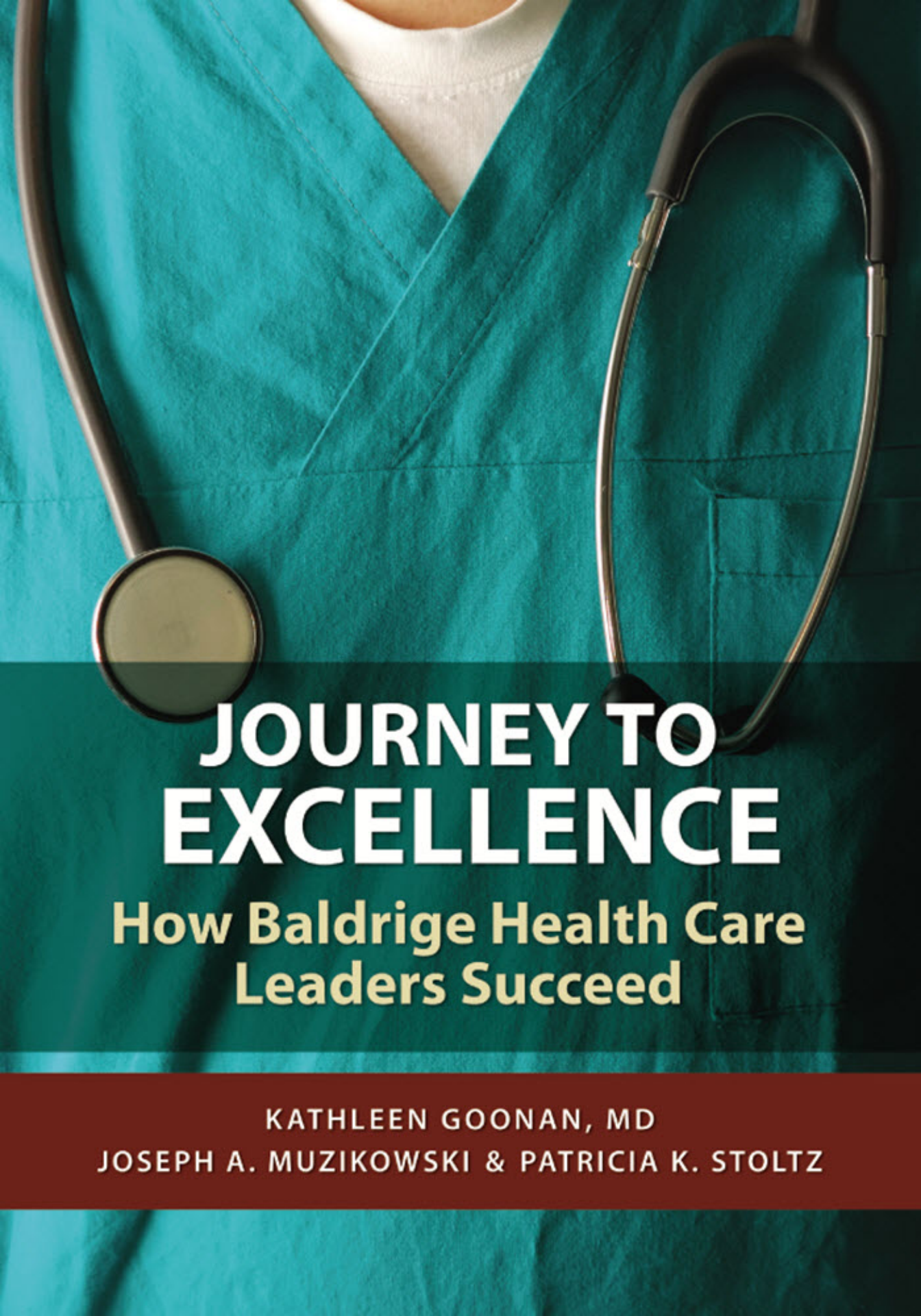

JOURNEY TO EXCELLENCE

How Baldrige Health Care Leaders Succeed

KATHLEEN GOONAN, MD
JOSEPH A. MUZIKOWSKI & PATRICIA K. STOLTZ

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Contents

List of Figures

Foreword

There are no secret answers. No magic bullets. But there are rational approaches that achieve results. This book is about those approaches and the results they achieve. This book is about the "brutal truth" health care organizations need to accept. It is about seeking the truth of your current reality for your organization, making sense of that reality, and changing the organization to achieve the results that lead to a sustainable reality, high performance, and engaged partners on your staff, among your patients, and in your community.

This book is presented in a compelling manner, with key points at the end of every chapter and many examples from real organizations that are succeeding through use of the Baldrige Criteria and a systematic approach to managing, improving, and changing their organization for the better. The Baldrige process provides discipline that many organizations never achieve. The authors provide a studied approach for achieving this discipline: the LASER elements (Leadership, Assessment, Sensemaking, Execution, and Results). They provide their insights from a unique vantage point. They are all experienced Baldrige examiners and judges, who have had the opportunity to assess the performance of many organizations. They combine that insight with a research study of Baldrige Award recipients, quoting from the recipients' discussions with them and sharing the recipients' processes for enterprise management. The result is "aha" moments that you will be able to apply directly to your organization. Then they synthesize what they have learned into useful tips, such as the five critical behaviors of successful leaders in Chapter 4 and important questions health care leaders should ask in Chapter 8.

In recent years, half of Baldrige Award applicants have been health care provider organizations. Thousands more are using the Baldrige Health Care Criteria. That is surprising when one compares the number of health care institutions with the much larger number of businesses and education institutions in the U.S., which make up the bulk of the other half. Why is this so? I believe it is because of a singular overlap between what the Baldrige Criteria provide and the challenges

health care is facing: to improve quality, to reduce cost, and to do it in a way that is strategically sustainable. If you can identify with this challenge, Baldrige might be right for your organization, and this book will give you easy insights to begin your journey.

Harry S. Hertz
Director
Baldrige National Quality Program

Preface

PURPOSE

Leading change in the best of times is difficult. In uncertain times, it is daunting. This book is for health care leaders at all levels seeking to guide successful transformational change even in the most challenging circumstances. We appreciate that this audience is broad and diverse, from senior executives to administrators and managers to clinicians, in complex organizations that vary substantially in size and scope of service. Our goal is to provide you with the strategy and knowledge to advance your personal effectiveness as an agent of change and help you lead your organization to greater achievements in performance.

This book is *not* a Baldrige educational manual, nor is it a "how to" book about the Baldrige process, although it includes lots of practical information about the successful use of Baldrige. Many resources are available to help you learn the Baldrige Criteria and how they are applied, starting with those provided by the Baldrige National Quality Program on its Web site, http://www.baldrige.nist.gov.

This book is about the strategy for leading successful change in a complex environment and what the nine health care organizations that have received the Baldrige Award since 2002 can teach us in this regard. All nine used the Baldrige framework and the Health Care Criteria for Performance Excellence as their diagnostic self-evaluation tool and guide for improvement. At the same time, each organization customized their use of Baldrige to fit their organizational culture, values, and goals. We learned many surprising lessons about the role Baldrige played—and did not play—in their accomplishments. This book focuses on the journeys of these nine organizations and seeks to convey what is common in their approaches that can help other health care leaders drive transformational change.

METHODS AND FINDINGS

The idea for this book first took shape in about 2002. Health care was under fire for quality and performance problems. Jim Collins had shown in *Good to Great* that certain organizational habits and disciplines could predict success. The Baldrige

process, effectively used for more than a decade by manufacturing and service companies, had opened to health care and the first recipient, SSM Health Care, had been named. And we had begun working with organizations seeking to create their own journey from "good to great" using the Baldrige Criteria.

Our experiences as Baldrige Award judges and examiners had allowed us to analyze the practices of some of America's highest performing organizations. We knew *what* those practices were. What we wanted to understand better was *how* organizations used Baldrige to transform and create truly high-performance cultures. We recognized the potential value for health care leaders of an in-depth and thoughtful analysis of how these organizations went about the job of making transformational change. Our curiosity and our sense of the importance of our question grew as the pressure on health care for better performance intensified, increasing numbers of health care organizations became Baldrige users, and new Baldrige Award recipients were named in the health care sector. Late in 2006, we launched our plan for this book.

We studied the application summaries of Baldrige recipients from health care and other sectors and material they presented at Quest for Excellence, the annual showcase of Baldrige recipient practices, and in other forums. We conducted in-depth personal interviews with twenty senior leaders from the nine health care recipients. Finally, we went back to the application summaries of our study organizations, their Quest for Excellence presentations, and our interviews to examine similarities and differences in their approaches to transformational change.

Two key findings emerged from our analysis. First, the recipient organizations we studied followed a common path once they started using Baldrige. Kate Goonan recognized this common path as a journey marked by five clearly discernible stages: Reaction (stage 0), Projects (stage 1), Traction (stage 2), Integration (stage 3), and Sustaining (stage 4). Second, we recognized that a set of critical activities, continually practiced and integrated one with another, seemed to support progress on the journey. These are the key components of what we came to call the LASER model: Leadership, Assessment, Sensemaking, Execution, and Results.

STRUCTURE

Chapter 1 lays out the context in which health care leaders work today and describes our overall findings. Here we introduce the "journey" and the stages of transformation that emerged from our research. Chapter 2 provides an overview of Baldrige and how it is used in the context of a larger change process. Our aim is to provide "just enough" basic information to understand the process and the journey taken by the nine health care award recipients. Readers with an in-depth knowledge of Baldrige may choose to skim or skip this chapter. Readers who are new to the subject, on the other hand, may want to download and review the Criteria before continuing with the remainder of the book. Chapter 3 offers a more detailed description of the journey, including the five stages and their sequence. This chapter provides the foundation for the LASER model practices. Chapters 4

through 8 describe each of the LASER elements in detail. Chapter 9 offers our conclusions. We designed these chapters so that the reader can benefit from reading each independently. If you choose to read the Leadership chapter and nothing else, you can skip to the Results chapter and Conclusion on a subsequent read. You might come back to the Assessment chapter at a time when you are seriously considering starting an assessment for your organization.

Each chapter features figures and side bars to illustrate recipient best practices and concludes with key points to summarize the chapter. At the end of the book, we address briefly a short list of the questions about Baldrige most often asked of leaders in health care recipient organizations and of us as consultants. Throughout this book, we quote extensively from our interviews to bring these health care leaders and their experiences to life as we illustrate their journeys. We also provide abundant examples of their practices and their results, primarily from publicly available material that you can explore yourself in more detail.

ACKNOWLEDGMENTS

Many valued colleagues contributed their talent and their time to support us in writing this book. First and foremost, we extend our deepest gratitude and admiration to leaders at the nine health care recipient organizations who made themselves available to us. At the end of the Preface, we list each organization and the individuals who contributed their expertise to this book.

We are indebted to others who made significant direct contributions to this book. Marsha Kessler, deputy director of the Massachusetts General Hospital Center for Performance Excellence, provided significant strategic and analytic support to the overall project. She created the database of research findings, worked as an essential partner with Kate Goonan on development of the LASER model by synthesizing the research findings and Kate's experience into a useful framework. She worked with the team of authors defined the details behind the elements of the model. Other colleagues made significant contributions: Marti Beltz, Sherry Bright, Steffanie Bristol, Len Denault, Jessica Marder, Sherry Martin, and Katherine Reller. In particular, we thank Sherry, Sherry, Marti, and Len, who offered helpful suggestions on our early drafts. We are grateful also to the dozens of leaders in organizations we have been privileged to support over the last six years. Partnering with them to shape their organizational change strategies has taught us so much and influenced our thinking in this work.

This book would not have been possible without the support of David Blumenthal, MD, director of the Institute for Health Policy, Massachusetts General Hospital/Partners, on leave to serve as the country's National Coordinator of Health Information Technology, Department of Health and Human Services. David is a visionary health care leader who recognized the potential power of the Baldrige process to change health care performance and provided us a spawning ground to test that hypothesis. Through his sponsorship, Massachusetts General Hospital/Partners supported the creation of the Center for Performance Excellence, home to our work as a team.

We also want to express our gratitude to Harry Hertz, director of the Baldrige National Quality Program, for his leadership of the program and for the insights and opportunities for learning he has shared with us as colleagues over many years. Each of us in our careers has been supported and influenced by other leaders and mentors. It would be difficult to name them all here and communicate their singular contributions to our knowledge. But we will always be grateful.

Finally, we want to thank our families. They have learned to tolerate our near obsession with this project and provided endless patience and support to us throughout.

Kate Goonan
Joe Muzikowski
Trish Stoltz

HEALTH CARE AWARD RECIPIENT ORGANIZATIONS AND LEADERS INTERVIEWED

2008 – Poudre Valley Health System

Poudre Valley Health System is a locally owned, private, not-for-profit health care organization serving residents of northern Colorado, western Nebraska, and southern Wyoming. Founded in 1925, it provides a full spectrum of health care services through two hospitals (Poudre Valley Hospital in Fort Collins, Colorado, and the Medical Center of the Rockies in Loveland, Colorado) and a network of clinics and care facilities.

Rulon Stacey
President and CEO
Poudre Valley Health System

Priscilla Nuwash
Director, Process Improvement
Poudre Valley Health System

Sonja Wulff
Performance Excellence Manager
Poudre Valley Health System

2007 – Mercy Health System

In 1989, Mercy Hospital was a single stand-alone community hospital primarily serving Janesville, Wisconsin. Today, Mercy Health System is a fully integrated health care system with three hospitals and a network of sixty-four facilities, including thirty-nine multi-specialty outpatient centers located in six counties throughout southern Wisconsin and northern Illinois. Mercy Health System provides a complete spectrum of integrated health care services to more than one million patients annually.

Javon R. Bea
President and CEO
Mercy Health System

2007 – Sharp HealthCare

Sharp HealthCare is San Diego County's largest integrated health care delivery system, serving greater than 27 percent of the county's more than three million residents—some 785,000 people—each year. A not-for-profit organization, Sharp has an annual net revenue of greater than $1.9 billion, employs a workforce with more than 14,000 staff members and 2,600 affiliated physicians, operates four acute care hospitals and nineteen outpatient medical clinics, and manages its own health insurance plan.

Michael W. Murphy
President and CEO
Sharp HealthCare

Nancy Pratt
Senior Vice President, Clinical Effectiveness
Sharp HealthCare

2006 – North Mississippi Medical Center

Established in 1937, North Mississippi Medical Center has grown from Tupelo's solitary "hospital on the hill" to the flagship hospital and referral center for North Mississippi Health Services, a not-for-profit health care delivery system serving twenty-four rural counties in northeast Mississippi and northwest Alabama. With more than six hundred beds, staffed by 3,875 employees and 277 physicians, North Mississippi is the largest non-government hospital in the state and the largest rural hospital in the country.

John Heer
President and CEO
North Mississippi Health Services

Ken Davis, MD
Former Chief Medical Officer
North Mississippi Medical Center

Jan Englert
Former Director, Clinical Outcomes
North Mississippi Medical Center

Chuck Stokes
Former President
North Mississippi Medical Center

2005 – Bronson Methodist Hospital

Founded in 1900, Bronson Methodist Hospital today is a state-of-the-art facility with all private rooms, the flagship organization in the Bronson Healthcare Group. Designed as a peaceful, healing environment, the hospital features an indoor garden atrium complete with lush trees, plants, and bubbling water. Located on a 28-acre urban campus, Bronson Methodist Hospital provides medical care for the nine-county region in southwest Michigan surrounding Kalamazoo, Michigan.

Frank J. Sardone
President and CEO
Bronson Healthcare Group

Michele Serbenski
Vice President, Performance Excellence
Bronson Healthcare Group

2004 – Robert Wood Johnson University Hospital at Hamilton

Located on a 68-acre campus, Robert Wood Johnson University Hospital at Hamilton is a private, not-for-profit, acute care community hospital serving more than 350,000 residents in Hamilton Township, New Jersey. The hospital is part of the Robert Wood Johnson Health System and Network and is affiliated with the University of Medicine and Dentistry of New Jersey – Robert Wood Johnson Medical School.

Ellen Guarnieri
President and CEO
Robert Wood Johnson University Hospital at Hamilton

Deborah Baehser
Senior Vice President, Clinical Services, and Chief Nursing Officer
Robert Wood Johnson University Hospital at Hamilton

Diane Grillo
Senior Vice President, Chief Learning and Communications Officer
Robert Wood Johnson University Hospital at Hamilton

2003 – Baptist Hospital, Inc.

The First Baptist Church of Pensacola, Florida, established Baptist Hospital in 1951 as a community-owned health care facility founded on Christian values. That single hospital evolved into Baptist Health Care, today the largest, most comprehensive health care system in the Florida Panhandle. Baptist Hospital, Inc., a subsidiary of Baptist Health Care, includes Baptist Hospital, a 492-bed tertiary care and referral hospital; Gulf Breeze, a 60-bed medical and surgical hospital; and Baptist Medical Park, an ambulatory care complex.

Al Stubblefield
President and CEO
Baptist Health Care Corporation

David Sjoberg
Vice President, Strategic Services
Baptist Hospital, Inc.

2003 – Saint Luke's Hospital of Kansas City

Founded in 1882, Saint Luke's Hospital is the largest hospital in the Kansas City, Missouri, metropolitan area. Affiliated with the Diocese of West Missouri of the Protestant Episcopal Church, it is a not-for-profit comprehensive teaching and referral health care organization that provides 24-hour coverage in every health care discipline. Saint Luke's is driven by its vision, "The Best Place to Get Care, The Best Place to Give Care," and its core values of Quality/Excellence, Customer Focus, Resource Management, and Teamwork. Specialized care capabilities for very ill people are Saint Luke's hallmark.

Eugene E. Fibuch, MD
Vice President and Medical Director for Quality
Saint Luke's Health System

G. Richard Hastings
President and CEO
Saint Luke's Health System

Sherry Marshall
Vice President, Quality
Saint Luke's Health System

2002 – SSM Health Care

Sponsored today by the Franciscan Sisters of Mary, SSM Health Care is a private, not-for-profit health care system based in St. Louis, Missouri. The system owns, manages, and is affiliated with 21 acute care hospitals and three nursing homes in four states: Illinois, Missouri, Oklahoma, and Wisconsin. Nearly 5,000 physician partners and 23,000 employees work together to provide a wide range of health care services through inpatient, outpatient, emergency departments, and ambulatory surgery settings. SSM Health Care offers additional services that include physician practices, residential and skilled nursing, home care and hospice, and information services.

Sister Mary Jean Ryan, FSM
President and CEO
SSM Health Care

Paula Friedman
Corporate Vice President, Strategy and Systems Improvement
SSM Health Care

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1
Introduction

"Knowing is not enough; we must apply.
Willing is not enough; we must do."

– Goethe[1]

Over the last decade, the U.S. health care system has endured mounting public scrutiny and declining public trust, prompted by well-researched and publicized evidence of far-reaching problems in safety, patient experience, and performance. After a half-century as a symbol of U.S. strength and extraordinary achievements in technologically advanced diagnostics and treatments, health care delivery is under fire from every direction for fundamental shortcomings in every facet of operational excellence.

Few people are happy with the current delivery system—not the people using it, the people working in it, or the people paying for it. For every story of medical triumph and human compassion, there are many more accounts of errors, ineffectiveness, and insensitivity. Good care happens almost in spite of organizational systems, too often requiring tremendous effort by patients, their families, and their health care professionals to overcome operational barriers.

The Centers for Medicare and Medicaid Services (CMS) is fully committed to transforming payment incentives into tools that reward quality and efficiency and exercising its legal authority to punish laggards.[2] CMS has put more hospitals on "Immediate Jeopardy" status for quality and safety problems in the last four years than in the preceding four decades, threatening to pull federal funding until issues are fully addressed.[3] Naturally, private payers follow the lead of CMS in such situations. In 2009, The Joint Commission instituted its own version of "Preliminary Denial of Accreditation" based on judgments about the immediacy of risk to patients.[4]

Providers and delivery systems ultimately control care and its quality and efficiency. To succeed in these challenging times, the focus must be on building the *capability* of provider organizations to deliver safe, reliable, and effective care.

Leaders of health care delivery organizations recognize and live with the consequences of this harsh environment every day. The forces of change and strategic challenges facing health care organizations—economic recession with rising unemployment, shrinking reimbursements, rapidly emerging safety and quality standards, expanding transparency on performance metrics, pay-for-performance, workforce shortages and poor staff morale, and consumer demands—create enormous turmoil for front-line health care providers and stress for their leaders. Over the last decade, most organizations have tried multiple strategies to address these challenges including quality improvement in its various forms and methods. Nevertheless, leaders typically find cultural transformation and sustainable performance excellence beyond reach for their organizations.

HEALTH CARE'S GROWING INTEREST IN BALDRIGE

In this unprecedented environment for health care, a startling trend has emerged highlighting a potential path forward for many health care organizations. The Malcolm Baldrige National Quality Award, the most competitive performance excellence award in the United States, has been dominated by health care applicants since 2002. As Figure 1.1 shows, since the Baldrige Award process opened to health care organizations in 1999, 40 percent of all applicants have come from this sector.[5] In 2007, 42 health care organizations applied at the national level, while 130 applied for state-level Baldrige-based performance excellence awards.[6] In 2008, there were 43 health care applicants for Baldrige. It is widely believed that award applicants are the tip of an iceberg of Baldrige users, organizations using the Criteria to integrate their developing business, operational, and quality activities around a culture striving for excellence.

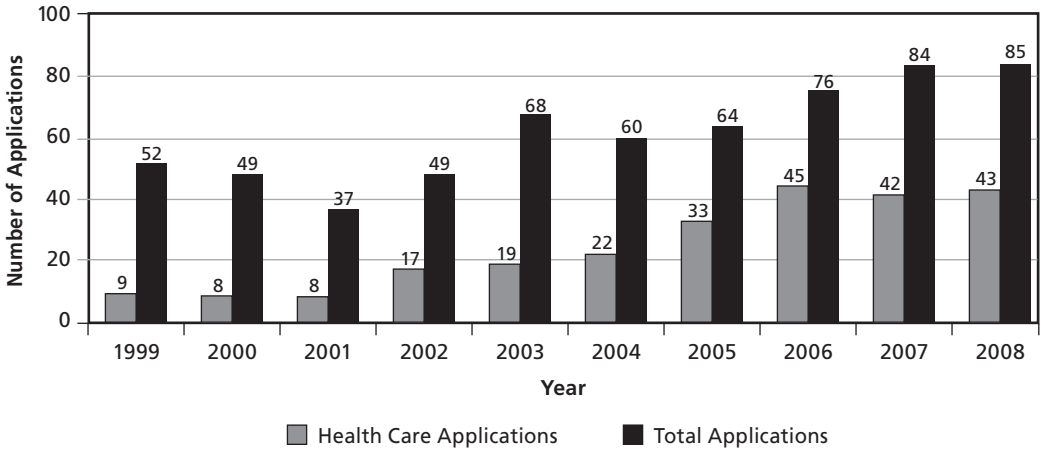

Figure 1.1 Baldrige applications by year.